(X6) DATE

Hawaii Dept. of Health, Office of Health Care Assurance

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4643 WAMMEA CANYON DRIVE WAMMEA, HI 95798 OSJ. 22/2019 PROVIDER'S PLAN OF CORRECTION PRIEDLY TAG OSS.REFERENCED TO THE APPROPRIATE DEFICIENCY) 4 000 Initial Comments A re-licensing survey was conducted by the Office of Health Care Assurance (OHCA) on 05/22/19. The facility was found not to be in substantial compliance with Chapter 11-94.1 Hawaii Administrative Rules. Survey dates: May 19, 2019 through May 22, 2019. Survey Census: 20 Residents. Sample Size: 12 Residents. 4 120 1-94.1-27(9) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative page, and the public upon request. A facility must protect and promote the rights of each resident, including: (9) The right to names, addresses, and telephone numbers of pertinent resident advocacy groups;	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4443 WAIMEA CANYON DRIVE WAIMEA, HI 96796 [(A4) ID SUMMARY STATEMENT OF DEFICIENCIES [(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)] A re-licensing survey was conducted by the Office of Health Care Assurance (OHCA) on 05/22/19. The facility was found not to be in substantial compliance with Chapter 11-94.1 Hawaii Administrative Rules. Survey dates: May 19, 2019 through May 22, 2019. Survey Census: 20 Residents. Sample Size: 12 Residents. 4 120 1-94.1-27(9) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, survogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (9) The right to names, addresses, and telephone numbers of pertinent resident	AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING:		COMPLETED		
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PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE		CHMMADV CT	<u> </u>	T	DDOWNERS DI AN OF CORDECTION	N .	0.450
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telephone numbers of pertinent resident		responsibilities of res stay in the facility sha be made available to legal guardian, surrou representative payee request. A facility mu	sidents during the resident's all be established and shall the resident, resident family, gate, sponsoring agency or a, and the public upon ust protect and promote the				
		telephone numbers of	of pertinent resident				
This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to verbally inform eight of 20 residents how to make a formal complaint to the state survey agency concerning suspected violation of state or federal nursing facility regulations. Ta. The Ombudsman attended the May 29th Monthly Resident Council Meeting and reviewed the process for filing a formal complaint concerning suspected violations of the state or federal nursing facility regulations with the residents. The meeting was conducted by the facility Social Worker. Handouts were provided.		Based on observation review, the facility fail 20 residents how to residents how to restate survey ager violation of state or foregulations.	n, interview and record led to verbally inform eight of make a formal complaint to ncy concerning suspected		29th Monthly Resident Council Meeti and reviewed the process for filing a formal complaint concerning suspecte violations of the state or federal nursir facility regulations with the residents. meeting was conducted by the facility	ed ng The	
During a meeting with eight Resident Council 1b. On 6/14/19, the facility also mailed a			h eight Resident Council		1b. On 6/14/19, the facility also mailed	d a	

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 06/17/19

TITLE

Hawaii Dept. of Health, Office of Health Care Assurance

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE				(X3) DATE SURVEY COMPLETED		
KAUAI VETERANS MEMORIAL HOSPITAL 4643 WAIMEA CANYON DRIVE WAIMEA, HI 96796 (X4) ID PREFIX PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 10 PREFIX PREFIX TAG 10 PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)			125021	B. WING		05/22/2019
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1/00 5 11 15	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETE
A 120 Continued From page 1 participants (Resident (R)1, R2, R10, R16, R17, R18, R119, and R120) on 05/20/19 at 11:15 AM when asked if they were given information how to file a formal complaint to the state survey agency they all answered no. Resident council meeting minutes dated May 31, 2018 to February 27, 2019 reviewed. No documentation found to indicate that residents were given written or verbal information on how to file a formal complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations. Facility admission packet reviewed: Patient rights & responsibilities brochure states under concerns and complaints how the resident or their representative can file a formal grievance or complaint. During an interview with the Social Worker (SW) on 05/21/19 at 02:17 PM regarding how the information is shared with the resident and resident's family how to file a formal complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations. The SW stated that at various intervals including the quarterly resident care conference review meetings the residents are informed which staff they can talk to about their complaints. It depends on what their complaint is who we refer the resident or their representative to. 14120 4120 4120 Copy of the "Hawaii Long-Term Care Ombudsman Information Brochure' along with "Kauai County" is fold call? replations of fold of 161 a formal complaint on the possibility of not knowing how to file a formal complaint is the possibility of not knowing how to file a formal concerns and complaints have the potential for the possibility of not knowing how to file a formal complaint is the state Survey Agency concerning and complaints have the potential for the possibility of not knowing how to file a formal concerns and complaint share the possibility of not knowing how to file a formal complaint of a formal complaint is family regulations. 3a. Twice a year, in the months of Jun	4 120	participants (Residen R18, R119, and R120 when asked if they we file a formal complain they all answered no. Resident council mee 2018 to February 27, documentation found were given written or file a formal complain Agency concerning astate or federal nursir Facility admission pack responsibilities brown and complaints how to representative can file complaint. During an interview won 05/21/19 at 02:17 information is shared resident's family how with the State Survey suspected violation or facility regulations. To intervals including the conference review me informed which staff to complaints. It depend who we refer the resident when we refer the resident who we refer the resident when the resident when the resident was a resident when the resident when	t (R)1, R2, R10, R16, R17, D) on 05/20/19 at 11:15 AM ere given information how to to to the state survey agency sting minutes dated May 31, 2019 reviewed. No to indicate that residents verbal information on how to to with the State Survey my suspected violation of ag facility regulations. Cocket reviewed: Patient rights chure states under concerns the resident or their ere a formal grievance or with the Social Worker (SW) PM regarding how the with the resident and to file a formal complaint. Agency concerning any festate or federal nursing the SW stated that at various erequarterly resident care eletings the residents are they can talk to about their discontinuation.	4 120	copy of the "Hawaii Long-Term Care Ombudsman Information Brochure" al with "Kauai County' S Got a Concern Who to Call?" phone listing to each resident of family/representative. 2a. All residents have the potential for possibility of not knowing how to file a formal complaint for any suspected violation nursing facility regulations. 3a. Twice a year, in the months of Jurand December, the facility will be mail copy of the "Hawaii s Long-Term Ca Ombudsman Information Brochure" al with the "Kauai County' S Got a Conce Who to Call?" phone listing to each resident s' family/representative to remind them of the process. 3b. The Social Worker will remind the residents of their rights and who to conshould they feel their rights have been violated at each of their Monthly Residents Council Meetings. These reminders we reflected in the minutes. 3c. The Ombudsman will be invited to attend Monthly Resident Council Meetings. These reminders we reflected in the minutes. 4a. The Combudsman will be invited to attend Monthly Resident Council Meetings with the residents. 4a. Twice a year, June and December Unit Clerk will provide the LTC Nurse Manager a list of who the brochures we mailed to and the date they were	r the of ne ing a re ong ern? thact if the dent ill be the ere ed. LTC

Office of Health Care Assurance

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(X3) DATE SURVEY

Hawaii Dept. of Health, Office of Health Care Assurance

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		,	A. BUILDING: _		COMPL	ETED		
125021		ı	B. WING		05/2	22/2019		
KAUAI VETERANS MEMORIAL HOSPITAL 4643 WAIM				DRESS, CITY, STATE, ZIP CODE MEA CANYON DRIVE				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE	
4 120	11-94.1-53(b)(2) Infection appropriate trans (2) At least one designated as an isolar shall have: (A) An adjoining system, a lavatory, are (B) Appropriate available to all staff; and the staff; and t	etion control have provisions for isolating us diseases until fers can be made. single bedroom shall be ation room as needed and toilet room with nurses' can da toilet; hand-washing facilities and	g	4 120	from each Monthly Resident Council Meeting. 4c. The Nurse Manager will monitor the following for compliance: - Bi-annual mailings of the LTC Ombudsman	g ed r	6/28/19	

(X2) MULTIPLE CONSTRUCTION

Office of Health Care Assurance

STATE FORM 5899 JXQC11 If continuation sheet 3 of 5

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		125021	B. WING		05/22/2019
	ROVIDER OR SUPPLIER	4643 WA	DDRESS, CITY, ST		
TOTOTI VE	TENANO MEMORIAL NO	WAIMEA	, HI 96796		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
4 205	Continued From page	3	4 205		
4 205	This Statute is not me Based on observation review, the facility faile equipment in accorda prevention and controt transmission of comminfections and to incordate of bedside equipprocedures. Findings include: During an observation 12:51 P.M., a Yankau attached tubing contate attached tubing contate the suction canister very label found to identify equipment was placed. During an interview wat 12:55 P.M., was querotocol when using sereplied "I never use it. During an Interview woo 1:00 P.M. when aske equipment and how lost stated that the nurse of the resident last night. During an Interview woo 1:31 P.M. stated "24 the time of use and all nurses should use the Standard and Transmit Policy and Procedure.	et as evidenced by: a, interview, and policy ed to maintain bedside nce with infection al standards to prevent the nunicable diseases and reporate routine cleaning and ment into their policy & a in room 12 on 05/20/19 at er Suction Catheter with ined thick yellow residue. vas soiled. There was no when the suction d. ith Staff (S) 13 on 05/20/19 reried as to what is the suction equipment. S13 ith S15 on 05/20/19 at	4 205	 1a. The suction canister, tubing, and yankauer suction catheter found in Ro 12 were disposed of on 5/20/19. 1b. All other resident rooms were also checked on 5/20/19 to verify no other suction canisters were in use. 2a. All residents have the potential to affected by this deficient infection contractice. 3a. The current General Nursing Infection Control Policy (500-125-1) was used a guide to create a new LTC specific Infection Control Policy (550-125-1). Specifics were added to 550-125-1 to the use of suction supplies to 72 hours Canisters will also be labeled when plin use to indicate start and discard datas. LTC Nurse Manager to review pos 550-125-1 (LTC Infection Control Polic with all staff; specifically to educate the on changes regarding suction supplies. This education will also be added to nemployee orientation. 4a. LTC Nurse Manager/designee to weekly spot checks on suction equipmin resident srooms to verify policy changes are being followed. 4b. Results from spot checks will be reported to HPIC for three consecutive meetings and/or until 100% compliance achieved. 	be trol ction as a limit s. acced se. sicy cy) em s. ew do nent
	that facility-approved	procedures for the routine sinfection of environmental		acilieved.	

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STATE FORM 5899 JXQC11 If continuation sheet 4 of 5

PRINTED: 06/26/2019 FORM APPROVED

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY	
		125021	B. WING		05	/22/2019
NAME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
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		ails, bedside equipment, and aces are being followed.	4 205			

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